Urban Wellness & Fertility Toronto
Intake Form
416.324.8888

General Health History

Date:_______________

Name: ______________________(M)(F) Date of Birth(D/M/Y): ___________ Age: ____

Address:____Postcode__________

Phone (h):________________(c)______________e-mail __________________

Occupation:____

Name of Doctor/Specialist: ______________________ phone:______________

Name of other Health Practitioners: _____________________________________

Emergency contact: ____________________________phone: ______________

Referred by: ____

From time to time we send out an electronic newsletter with our upcoming workshops, events and talks, healthful ideas, recipes and inspirations. Are you interested in receiving this?
____

What is the main condition for which you are seeking treatment?
____
____

What is the history of this condition (ie. when did it start, what makes it worse/better? what have you already tried for treatment?)
____
____
____

Previous Medical History:
List any previous **illnesses** including childhood illness or chronic viral infections, any **surgeries**, **traumas** or accidents, even if unrelated to your current condition.
____
____
____
____

Are there any conditions that are significant in your **family's medical history**?
(eg. heart disease, cancer, stroke, high blood pressure, kidney disease, diabetes, asthma, ulcers, mental/emotional disorders, etc)
____
____

Please list any allergies and the reaction you have:
____
____

Please be assured that your information is confidential and will be shared only with your practitioners.

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Lifestyle:
Diet – List what you might eat on a typical day:
____
____How is your appetite? ____
How often do you have a bowel movement? _____________________________
What medications or supplements are you currently taking and for what reason?
____
____
Do you drink coffee? ______ If so, how many cups per day?_______
Do you drink alcohol? ______If so, how much and how often? ________
Do you smoke? ________ If so, how many cigarettes per day? ________
Do you use recreational drugs? ________ If so, how often? _________
How many cups of water do you drink in a day? _________

Exercise – What is your typical activity in a day?
____
____
Are you on a regular exercise program? (type of activity and frequency)
____
____

Relaxation – What is your level of personal and occupation related stress?
____
When you are under stress, what is your most common emotional response? (please check all that apply)

__sadness __anger __worry __anxiety
__depression __ fear

What do you do for relaxation? How often do you actively relax?
____
____

How many hours of sleep do you get each night? _________________________
Do you feel rested when you wake up? _________________________________

Do you have a TV in your bedroom? _______ a computer? __________
Do you work at a computer? ______ Do you use a cellphone? _________

What are your expectations from our work together?
____
____
____

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Mark **current** symptoms **"C"** Mark **past** symptoms **"P"**

General
- ❑ Fatigue
- ❑ Insomnia
- ❑ Disturbed sleep
- ❑ Frequent dreams
- ❑ Excessive sleep
- ❑ Dislike cold
- ❑ Dislike heat
- ❑ Weight loss
- ❑ Weight gain
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Daytime sweating
- ❑ Usually thirsty
- ❑ Seldom thirsty
- ❑ Edema or swelling
- ❑ Other ___________

Skin
- ❑ Rashes
- ❑ Hives
- ❑ Dry skin
- ❑ Acne
- ❑ Bruise easily
- ❑ Changes in moles
- ❑ Unusual bleeding
- ❑ Other ___________

Head and Neck
- ❑ Headaches (location and type of pain)
- ❑ Dizziness
- ❑ Jaw pain
- ❑ Other __________

Eyes and Ears
- ❑ Failing vision
- ❑ Blurred vision
- ❑ Visual spots
- ❑ Night blindness
- ❑ Eye pain or redness
- ❑ Ringing in the ears
- ❑ Decreased hearing
- ❑ Ear pain/discharge
- ❑ Other ____________

Nose, Throat and Mouth
- ❑ Nosebleeds
- ❑ Nasal discharge/ infection
- ❑ Frequent sneezing
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult swallowing
- ❑ Tooth or gum pain
- ❑ Bleeding gums
- ❑ Mouth ulcers
- ❑ Other _____________

Muscles and Joints
Pain, weakness or numbness in:
- ❑ Neck/shoulder/arm
- ❑ Hips/leg/feet
- ❑ Low back & knees
- ❑ Muscle cramps
- ❑ Body pain
- ❑ Heavy limbs
- ❑ Swollen joints
- ❑ Hot joints

Nervous System
- ❑ Fainting
- ❑ Paralysis
- ❑ Tremors
- ❑ Poor balance
- ❑ Seizures
- ❑ Other ____________

Heart, Lungs & Chest
- ❑ Palpitations
- ❑ Chest pain
- ❑ Chest tightness
- ❑ Rapid heart beat
- ❑ Irregular heart beat
- ❑ Swelling of ankles
- ❑ Cough
- ❑ Dry cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Short of breath
- ❑ Asthma/wheezing
- ❑ Frequent colds
- ❑ Pain in rib cage
- ❑ Other ___________

Mental/Emotional
- ❑ Difficult concentrating
- ❑ Poor memory
- ❑ Worry
- ❑ Anxiety
- ❑ Depression
- ❑ Irritability
- ❑ Frustration or anger
- ❑ Fearfulness
- ❑ Stress
- ❑ Other _____________

Digestive System
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Loose stools
- ❑ Stomach pain
- ❑ Abdominal pain
- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Abdominal bloating
- ❑ Belching
- ❑ Indigestion
- ❑ Acid reflux
- ❑ Hemorrhoids
- ❑ History of eating disorder

Urinary/Genital
- ❑ Painful urination
- ❑ Difficult urination
- ❑ Frequent daytime
- ❑ Nighttime urination
- ❑ Incontinence
- ❑ Cloudy urine
- ❑ Genital pain or itch
- ❑ Genital discharge
- ❑ Low sex drive
- ❑ Excessive sex drive
- ❑ History of STD _______

Female
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Spotting
- ❑ Passing clots
- ❑ Scanty or no periods
- ❑ Early periods
- ❑ PMS
- ❑ Menopausal symptom
- ❑ Abnormal PAP smear
- ❑ Vaginal discharge
- ❑ Breast lump
- ❑ Breast pain/discharge
- ❑ Other ______________

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